Midwest Business Group on Health
Powerful Connections, Vital Solutions

Comments to the Health Reform Implementation Council on "Essential Health Benefits"
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The Midwest Business Group on Health (MBGH) is a non-profit, Chicago-based, business coalition that represents over 100 primarily large public and private employers, most of whom have headquarters or operations in Illinois such as Abbott Labs, Boeing, Caterpillar, City of Chicago, Advocate, and Walgreens, who voluntarily spend over $3 billion to provide health benefits and other health programs to over 3 million employees, retirees, and their families.

Our members employ and provide health benefits for employees under a wide variety of work arrangements, including full-time, part-time, seasonal, and temporary; usually offer their employees a choice of several plan options; and often operate multiple lines of business in multiple locations—often in all 50 states. However, most employers in Illinois are small, with under 50 employees and their interests are our interests, as many are suppliers of our large employer members.

We support the State's efforts to balance comprehensiveness and affordability in establishing and implementing an EHB definition. It's critical that the State recognize the potential impact its decision will have on both large and small employers, as well as the opportunity to improve the quality and effectiveness of health benefits, while reducing unnecessary costs.

Our recommendations, in brief, are that in developing the EHB definition, the Council must:

1) **Not put the cost of coverage beyond the reach of small businesses, their employees and individuals, nor add administrative and benefit expenses to large, multi-state firms;**

2) **Be flexible on setting a minimum value of benefits;**

3) **Understand that the type of plan and its payment approach are intimately linked, affecting how providers manage and provide care to patients, and you can't merely select a set of benefits from a plan and ask that other plans meet its value without taking consideration of its total design;**

4) Incorporate into the EHBs leading edge benefit designs and strategies that are essential to ensure the plans offer safe, quality, value-based, cost-effective coverage;

5) Develop reasonable limits to promote effective care, prevent unnecessary care, and keep EHB affordable;

6) Apply cost and medical effectiveness considerations to all benefits, including state mandates.

7) Review and update the EHBs periodically for evidenced-based appropriateness and to reflect changes in state mandates.

Our recommendations for your consideration are as follows:

1. **Be aware your decisions will also impact Illinois-based, multi-state, self –funded employers who will have to meet the various requirements of each state where they operate, which raises expenses for administrative and benefit operations.**

   Although the Affordable Care Act does not require self-insured group health plans to cover EHB, the definition nevertheless will have a significant impact on such plans.

   -Many do offer insured HMO plans and more will offer insured plans from private exchanges. Will plans offered through the private exchanges also be required to meet the EHB requirements?

   - In the future all group health plans must comply with the Affordable Care Act's prohibitions on lifetime and annual dollar limits on EHB. Our members already have devoted significant financial, administrative, and staff resources to complying with Affordable Care Act and other federal requirements. Therefore, regulatory provisions that increase administrative and benefit costs are of particular concern for our members.

   -Some participants in our members' plans likely will be eligible for coverage from the State's Health Benefit Exchange, which is subject to EHB requirements.

   - The essential health benefits requirement also impacts large group and self-insured health plans in the context of the ACA's prohibitions on annual and lifetime dollar limits. Pursuant to PHSA section 2711, if a large group health plan or a self-insured plan voluntarily provides coverage for essential health benefits, then such plan is required – with respect to those benefits that are essential health benefits – to comply with the restrictions regarding the use of certain lifetime and annual dollar limits.

2. Concerns about setting a minimum value for EHB

- Despite the proposed requirement that all plans must meet the actuarial value of the benchmark plan, it is important that any future guidance on the "minimum value" of employer-sponsored coverage both acknowledge and stay within the bounds of the express statutory language. We do not believe that Congress intended, or that the text of IRC section 36B(c)(2)(C)(ii) permits, the State or HHS to impose a certain minimum value test on employer-sponsored plans. However, there does seem to be a requirement that the actuarial value of the benchmark is where all other plans must attain.

- We are concerned that such an approach would not only increase the cost and complexity for employers of providing coverage to employees, but also lead to some employers exiting the system altogether. Moreover, large employers have a significant interest in providing comprehensive benefits that will best keep their workforces healthy. For these reasons, we strongly urge the Department to not impose a specific minimum value test as part of any guidance issued regarding minimum value.

3. Understand that the type of plan and its payment approach are intimately linked, affecting how providers manage and provide care to patients, and you can't merely select a set of benefits from a plan and ask that other plans meet its value without taking consideration of its total design.

- The most cost-effective health plans use incentives or capitation to motivate or reward providers to manage the health of their patients and encourage use of preventive services, adherence to medications and participation in wellness/health condition management programs.

- You don't get the same outcomes from plans that have similar benefits, but don't use the same incentive programs or payment methods.

- It would be like requiring all cars to offer the same features of the Chevy Volt – an electric car – and expect the same mileage.

4) Incorporate private sector strategies into EHB packages to achieve greater benefit value and affordability

- Private sector benefit design, medical management and care delivery approaches have helped achieve greater benefit value and affordability. The innovation and new ideas, such as value-based benefit design, the private sector provides can be used to increase

the effectiveness and desired outcomes of the State. MBGH strongly urges the State to ensure that health plans can continue to use these strategies employed in the commercial market to improve quality, outcomes and value.

- We are concerned that the regulatory approach described in the Essential Health Benefits Bulletin may not accommodate plan design features that promote clinical effectiveness, efficiency, and value-based benefit design. This result would run contrary to the Affordable Care Act's—and our members'—goal of controlling the overall costs of health care.

- To prevent health care expenditures on unnecessary, redundant, and ineffective care, we strongly support basing EHB on services or treatments with demonstrated evidence of clinical effectiveness.

The following is a list of best management practices that leading-edge employer-sponsored plans incorporate to promote efficiency:

• **Evidence-Based Benefits.** Linking coverage to the effectiveness of treatments and setting cost-sharing, provider selection, and plan payments to support evidence-based care and discourage ineffective care. For example: reducing or eliminating copayments for maintenance drugs prescribed for diabetes, asthma, and hypertension where the evidence base for the drugs' effectiveness is strong.

• **Using the "eValue8" Request for Information Tool.** The eV8 RFI is used by employers around the country to determine the performance of health plans in clinical, administrative, satisfaction, provider payment, patient education, mental health, pharmacy benefit and other areass

• **Targeted Evidence-Based Preventive Care.** Providing incentives such as first dollar coverage (or little or no copayment) for evidence-based preventive care services for targeted populations to improve participant health and reduce future health care costs. Offering education programs to improve plan participant awareness of preventive care. Consideration should be given to incorporating USPSTF guidelines.

• **Emphasis on Primary Care.** Paying more for care coordination and patient management and evaluation services. Choosing providers who incorporate the "patient-centered medical home" concept and emphasize primary care coordination.

• **Meaningful Cost-Sharing.** Setting cost-sharing for plan participants at levels that reduce excessive and inappropriate utilization but ensure access to needed medical care when appropriate. Varying cost-sharing based on clinical necessity and therapeutic benefit. For example: Reducing cost-sharing when participants meet requirements fostering evidence-based care such as using medical consultation services and decision supports, participating in disease or case management, etc.

• **Prescription Drug Management.** Managing prescription drug use and pharmacy spending by establishing plan preferences for select generics and brand-name drugs. Considering "step" therapy, generic substitution requirements, or incentives, generic education programs for plan participants and physicians, a separate deductible for prescription drugs, preauthorization for selected drugs, reduced cost sharing for mail order compared to retail purchase, mandatory mail order of maintenance medications, tiered copayments, coinsurance rather than copayments for medications, dose optimization, and quantity-duration protocols for certain medications.

• **Reference-based Pricing.** Setting the benefit level to the median rate of quality providers offering the same level of service, and making the individual pay more to go elsewhere.

• **Health Improvement Programs.** Offering incentives such as premium discounts to participants who participate in health improvement programs and adopt healthier lifestyles.

• **Targeted Disease Management Programs.** Providing targeted disease management programs for certain chronic and potentially high-cost conditions where evidence demonstrates their effectiveness. Using incentives, rewards, and premium discounts to encourage participation.

• **Retail/Convenience Care Clinics.** Offering access to retail clinics for common, basic medical services to add convenience and reduce inappropriate emergency room visits. Promoting services at retail/convenience care clinics to plan participants through education campaigns and offering lower copayments for the services clinics provide.

• **Consumer Decision Support Tools.** Offering decision-support tools (plan selection and point-of-care) to help plan participants make informed decisions about their health and the comparative effectiveness of procedures, drugs and devices. Tools include customized comparison and financial modeling to help individuals choose among plan options; hospital and physician report cards to assess provider performance against evidence-based standards; nurse lines; self-care guides; self-study modules; online information; health coaches, health advocates; and consumer medical information services to give plan participants more information about treatment options for conditions or illnesses. Requiring that plan participants use decision-support services before non-emergency surgery.

• **Pay-for-Performance.** Linking plans' provider payments to health care quality, paying more for better outcomes, greater efficiency, and better performance on prevention, chronic care management, and patient satisfaction measures. Providing financial incentives to plan participants to choose better performing providers. Don't pay for unnecessary re-admissions, preventable errors, or preventable adverse events (i.e., leaving a sponge in after surgery.).

• **High-Performance Networks.** Using smaller, high-performance networks to reduce costs and improve quality. Offering specialized services through facilities that meet criteria for volume and clinical outcomes, patient and family-oriented services, and evidence-based medicine. Implementing pay-for-performance arrangements and providing incentives to patients who select high-quality, cost-effective facilities. For example: Offering a preferred tier of medical groups and hospitals with differential copayments based on performance in quality and costs.

• **Health Information Technology (HIT).** Requiring health care vendors to use interoperable HIT wherever possible. Providing personal health records for plan participants.

• **Transparency (Cost and Quality).** Requiring plans and providers to publicly disclose information about the price and quality of care.

5. Develop reasonable limits to promote effective care, prevent unnecessary care, and keep EHB affordable.

- It's unclear to us how "benefit administration" is to be defined under the proposed approach. The "Basic Facts" document provided by the State says the State can't " *set guidelines around benefit administration, such as the premium, deductibles, co-payments, and other cost-sharing features.*"

- Depending on "benefits administration" is defined, it could restricts the ability of the State to take advantage of the significant role of limits on covered benefits in both employer and government-sponsored coverage.

- Employer-sponsored plans routinely place limits on a number of services, including the following, to keep care affordable: Bariatric coverage for weight loss; Chemical dependency; Chiropractic benefits; Dental coverage: Vision coverage; Durable medical equipment; Hearing aids; Home health care/hospice; Infertility benefits; Out-of-network benefits; Physical and speech therapy; and how preventive services are defined.

- Government health benefit programs, including Medicare, the Federal Employees Health Benefits Program (FEBHP), and Medicaid, also routinely place limits on benefits. For example:

  • FEHBP's Blue Cross/Blue Shield basic option plan places a 75 visit annual limit on physical, speech, and occupational therapy sessions.

  • Medicare utilizes a 190-day lifetime limit on inpatient psychiatric care; limits coverage for chiropractic care and a variety of other services; and does not cover acupuncture; dental care and dentures (in most cases); cosmetic surgery; custodial care (help with bathing, dressing, using the bathroom, and eating) at home or in a nursing home; health care while traveling

outside of the United States (except in limited cases); hearing aids and hearing exams; or orthopedic shoes.
• Medicare prescription drug coverage (Part D) utilizes prior authorization, "fail first," and "step therapy" requirements and quantity limits.

6. Apply cost and medical effectiveness considerations to all benefits, including state mandates.

Development of the EHB package should incorporate evaluations of benefits, including state benefit mandates, from both a cost and medical effectiveness perspective. MBGH recommends that in order to ensure affordability, we encourage the State to undertake a review of its most costly benefit mandates, using the method described by the IOM in its recommendations to HHS on defining EHBs, and exclude state-mandated benefits that lack a strong evidence-base after the transition period (2014-2015).

We also recommend that the benchmark plan chosen be one that limits or does not include the state's benefit mandates. Such benefit mandates often are the result of advocacy by provider, supplier, or patient groups rather than strong clinical evidence justifying coverage of the benefits at issue. For example, in the case of high-dose chemotherapy with autologous bone marrow transplantation (HDC/ABMT), this state-mandated care was found to be more harmful than the conventional treatment at the time.

7. Allow for the update Essential Health Benefits

HHS has proposed updating EHB periodically. We recommend the State plan to do so as well. In the future, advances in personalized medicine will require a more individualized approach to coverage decisions. In addition, the speed at which new, costly medical technologies are coming to market will create a need for objective, evidence-based assessments to ensure patient safety, quality, and affordability. Both of these factors highlight the necessity of frequent and regular reevaluation of EHB. Such reevaluations should identify not only benefits to be added but also existing "essential health benefits" that may need to be eliminated because of new medical evidence.

Thank you for considering our comments and recommendations on the proposed regulatory approach to defining "essential health benefits." We look forward to working with you as you continue to implement the various provisions of the Affordable Care Act. Please contact, at (312) 372-9090 x 101 or lboress@mbgh.org if you would like to discuss our comments or other aspects of the ACA or health benefits or worksite health issues.